

SUPPLEMENT TO

**M A N A G E D**

# Care

## The Future of Medicaid What Will Medicaid Look Like in 2010?

Based on the proceedings of a symposium  
at the University of the Sciences in Philadelphia, May 12, 2004

### HIGHLIGHTS

The Challenges Medicaid Faces: Funding and Its Role

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4 Perspectives on Medicaid's Present and Future

- We Ask a Lot of Medicaid but Don't Fund It Accordingly
  - Realigning Medicaid Means Realigning Incentives
  - Primary Policy Considerations: Funding and Flexibility
  - An Optimistic Perspective: Medicaid as Cinderella
- 

Roundtable Discussion: Where Do We Go From Here?

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## INTRODUCTION

ROBERT I. FIELD, JD, MPH, PhD  
*Director, Graduate Program in Health Policy  
Associate Professor of Health Policy  
University of the Sciences in Philadelphia*

### What Should Medicaid Look Like in 2010?

**M**edicaid is an often-invisible cornerstone of America's health care finance system. While less evident than Medicare in the public eye, it is the largest health insurance program in the United States. Medicaid provides coverage for more than 50 million poor and disabled Americans and spends in excess of \$300 billion a year. It is actually a set of partnerships between each state and the federal government, in which funding and oversight are shared. As a result, it is probably the most complex health care program.

The importance of Medicaid would be difficult to overstate. It accounts for 20 percent of national health care spending. It is America's largest financier of obstetrical care, covering more than a third of all births, and provides coverage for almost one fourth of American children. It finances half of all long-term care and half of public mental health spending. Without Medicaid, the ranks of America's uninsured would swell to more than 90 million — or almost 1 of every 3 citizens.

As a federal-state partnership, Medicaid is buffeted by politics at both levels. State budget crises tend to affect it directly, with federal fiscal politics always lurking in the background. Where is Medicaid headed? What can and should we expect of our largest health care finance program? These questions are no less important to the future of American health care than the direction of Medicare.

University of the Sciences in Philadelphia brought together five leading experts on Medicaid to consider its future. With Diane Rowland, ScD, of the Henry J. Kaiser Family Foundation as moderator, a panel representing varied viewpoints and interests sought to define challenges and craft a consensus on solutions. Joining the debate were former Michigan Gov. John Engler; Nina Owcharenko of the Heritage Foundation; Alan Weil, JD, of the Urban Institute; and Joy Wilson of the National Conference of State Legislatures.

All saw a role for Medicaid that far surpasses its public image. Policy makers should treat it less as a welfare program and more as a mainstay of the health care system. This supplement contains several clear, specific suggestions on how to accomplish this. Improving Medicaid is crucial because it will do much to define the overall shape of American health care.



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#### INTRODUCTION

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DIANE ROWLAND, ScD, moderator

JOHN ENGLER, JD; NINA OWCHARENKO; ALAN WEIL, JD; and JOY WILSON, panelists

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## MODERATOR'S OVERVIEW

# The Challenges Medicaid Faces: Funding and Its Role

Diane Rowland, ScD



**W**hat Medicaid will look like in 2010 depends on two factors: what Medicaid is today and what America wants, needs, and is willing to pay for Medicaid to be tomorrow. This article examines current realities and explores future possibilities with respect to Medicaid.

### **Enormous, complex, inconsistent**

Fifty-two million people benefit from Medicaid, a partnership between the federal government and the states (including the District of Columbia and U.S. possessions<sup>1</sup>). It provides comprehensive, low-cost health coverage for about 39 million people in low-income families and serves as the primary source of acute- and long-term care coverage for 13 million more disabled and economically disadvantaged individuals.

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*Diane Rowland, ScD, is executive vice president of the Henry J. Kaiser Family Foundation and executive director of the Kaiser Commission on Medicaid and the Uninsured. She is also an adjunct associate professor in the Department of Health Policy and Management at the School of Hygiene and Public Health of Johns Hopkins University. She served on the staff of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce of the U.S. House of Representatives and has held senior health policy positions in the Department of Health and Human Services in the Office of the Secretary and the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services).*

As an entitlement program, Medicare provides health care services to all who meet the established criteria; it also guarantees federal funds matching qualified state payments for the health care of eligible Americans.

In 2003, the Medicaid program spent \$175 billion in federal funds and \$120 billion in state funds to provide mandated services to eligible persons. Currently, Medicaid is bigger than Medicare, paying 1 of every 5 health care dollars spent in the United States, 1 of every 2 long-term care dollars, and more than half the money paid for public mental health services. Medicaid is the largest source of federal aid to the states, accounting for 43 percent of all state-bound federal funds.

Because Medicaid is a federal/state partnership, it is tailored to recognize the needs of geographically diverse populations. The U.S. government dictates which health care services are eligible for federal compensation and establishes matching-funds rules.

Nationwide uniformity ends there, however, as each state's government is free to design aspects of its particular program, including some eligibility levels, scope of services, and provider payment amounts. A thorough analysis of how each of the 50 states manages the multiple responsibilities and components of its Medicaid program would be likely to reveal as many as 1,000 program variations and permutations.

## **Mission**

Medicaid provides health care coverage for low-income children, parents, and certain adults without children. To establish eligibility and determine matching-fund contributions to the states, Medicaid uses the following federal definitions (based on annual income for a family of three in 2002, the last year for which complete figures are available):

- Federal poverty level (FPL): \$14,348
- Low income: Less than 200 percent of the FPL (\$28,696)
- Near-poor: Between 100 percent and 199 percent of the FPL
- Poor: Below 100 percent of the FPL

*Children.* While Medicaid and its companion program, the State Children's Health Insurance Program, exist to provide broad health care coverage to low-income children, many near-poor and poor youngsters remain uninsured because of barriers to enrollment. Both programs are challenged to find and enroll these children by improving outreach, simplifying forms, and generally enhancing access.

*Parents.* In most states, children whose families have an annual income of 200 to 250 percent of the FPL are eligible for Medicaid. In stark contrast, Medicaid eligibility income levels for parents are based on welfare eligibility levels established by the states, are much lower than those for children, and have not been raised. Consequently, many children are eligible to receive Medicaid benefits while their parents are not. Extending Medicaid coverage to entire families will extend benefits to some of the children who are eligible but not enrolled because their parents cannot obtain the same program's benefits.

*Childless adults.* Medicaid has never been an insuring vehicle for low-income adults without children, although there are exceptions — pregnant women, the poor

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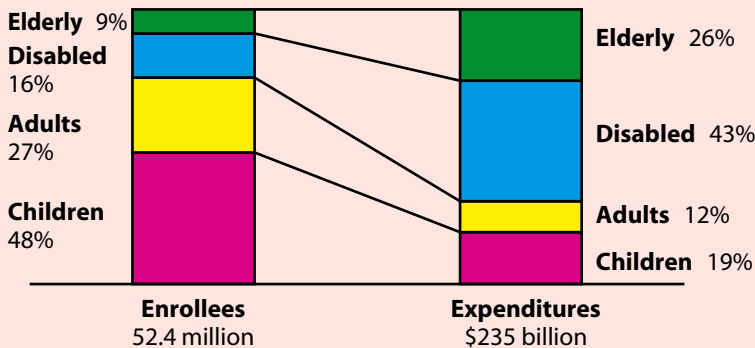
<sup>1</sup> American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

elderly, blind, and disabled — and those leaving state welfare programs who need health care coverage. Federal law currently provides matching funds to *children and their parents*. States may expand coverage to currently noneligible childless adults only by obtaining a waiver, but few have been able to do that.

### Cost drivers

In large part, Medicaid costs are driven by the program's integration with Medicare. Enacted in 1965, along with Medicare, Medicaid historically has been the program that makes Medicare work for low-income Medicare beneficiaries. If not for Medicaid, many of the neediest Medicare beneficiaries would be unable to afford Medicare Part B premiums, receive certain medications and other benefits not covered by Medicare, or have access to long-term care services.

**FIGURE 1 Medicaid enrollees and expenditures by enrollment group, 2003**



SOURCE: KCMU 2004, BASED ON DATA FROM THE CONGRESSIONAL BUDGET OFFICE AND THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET

The “face” of Medicaid is the low-income child; 48 percent of enrolled beneficiaries are economically underprivileged youngsters; yet only \$19 of every \$100 in Medicaid is spent to provide full health care coverage to children. The rest is used to plug the gaps in Medicare coverage and provide long-term care for the elderly (Figure 1).

Last year, on average, Medicaid spent \$1,700 per child, compared with \$12,800 per older adult (at least age 65), primarily because the elderly generate more long-term care expenses. Medicaid spent \$12,300 per disabled beneficiary and \$1,900 per disadvantaged nondisabled adult (Urban Institute 2002).

### CHALLENGES

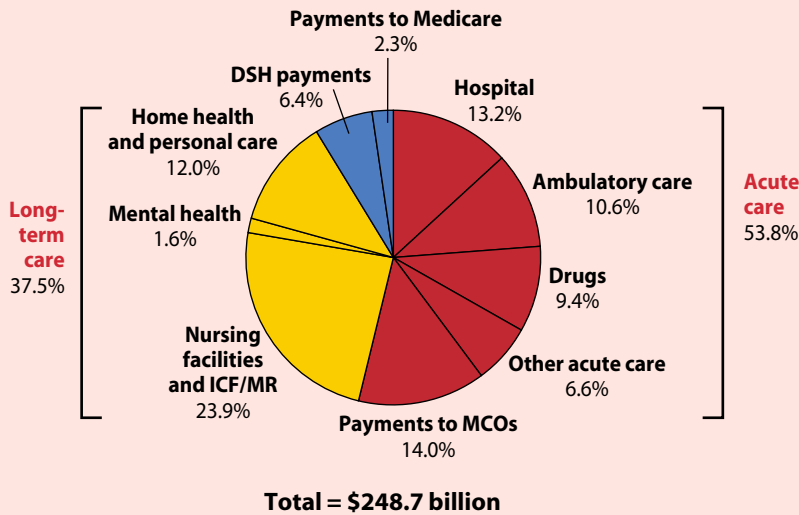
Defining the current and future role of Medicaid, particularly in terms of how the program meshes with private insurance and other health care coverage, is central to meeting the challenges associated with resolving the problem of providing health insurance to the entire American population, at least to the extent possible.

*The uninsured.* Currently, 16 percent of uninsured low-income Americans are children; their parents represent another 16 percent. Providing Medicaid benefits to these persons would reduce the uninsured U.S. population by about two thirds. Providing Medicaid matching funds to low-income childless adults would reduce that figure even further.

*Dual eligibles.* In essence, Medicaid pays for most of the care provided to dual eligibles — persons who qualify for both Medicaid and Medicare. About 7 million Medicaid enrollees are dual eligibles, receiving Medicare assistance because of their disability or age (Crowley 2003). Both physically and financially, dual eligibles are among the neediest Medicare recipients. About dual eligibles:

- Most are low-income persons, by definition.
- Many are in only fair or poor health, when compared with single-eligibility Medicare beneficiaries.

**FIGURE 2 Medicaid expenditures by service, 2002**



DSH=disproportionate share of hospital payments, ICF/MR=Intermediate care facility for the mentally retarded.

SOURCE: URBAN INSTITUTE 2002

- Twenty-two percent reside in long-term care facilities or nursing homes.
- About one fourth have diabetes.
- They are more likely than other Medicare recipients to suffer a stroke or develop Alzheimer’s disease.

Of the \$232.8 billion Medicaid paid in benefits during fiscal year 2003, \$82.7 billion bought nonprescription medications and \$13.4 billion bought prescription medications for dual eligibles, accounting for 42 percent of total Medicare disbursements but only 6 percent of overall Medicaid spending.

Under the recently enacted Medicare drug legislation, dual eligibles will become eligible solely for Medicare coverage starting in 2006. This is no financial windfall for the states, however, as Congress is attempting to balance its budget by requiring states to reimburse Medicare for drug coverage of dual eligibles, nullifying the apparent gain.

Whether federal or state funds pay these costs, the graying of America virtually ensures that these costs will rise faster than state revenues or federal funds used to provide coverage.

*Long-term care.* As an obvious consequence of covering dual eligibles, Medicaid is a major provider of long-term care. In 2002, long-term care accounted for about three eighths of overall Medicaid spending (Figure 2).

Nursing-home care costs an average of \$40,000 to \$50,000 per year. Of the \$103 billion spent on this type of care in the United States in 2002, Medicaid paid half. Home health care and community-based services also represent a major Medicaid commitment; the program paid 23 percent of the \$36 billion paid for this type of care in 2002 (Levit 2004).

Recent court rulings, particularly the Olmstead decision (see “The Olmstead De-

## The Olmstead decision

The U.S. Supreme Court's decision in the Olmstead case will have a major financial effect on Medicaid.

According to the National Conference of State Legislatures, "The 1999 Supreme Court ruling in *L.C. & E.W. vs. Olmstead* interpreted the Americans with Disabilities Act (ADA) to mean that states must provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (Fox-Grage 2002).

The Centers for Medicare and Medicaid Services adds that Olmstead "clearly challenges federal, state, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services.

"The Olmstead decision interpreted Title II of the Americans with Disabilities Act and its implementing regulation, requiring states to administer their services, programs, and activities 'in the most integrated

setting appropriate to the needs of qualified individuals with disabilities.'

"Medicaid can be an important resource to assist states in meeting these goals. However, the scope of the ADA and the Olmstead decision are not limited to Medicaid beneficiaries or to services financed by the Medicaid program. The ADA and the Olmstead decision apply to all qualified individuals with disabilities regardless of age" (CMS 2002).

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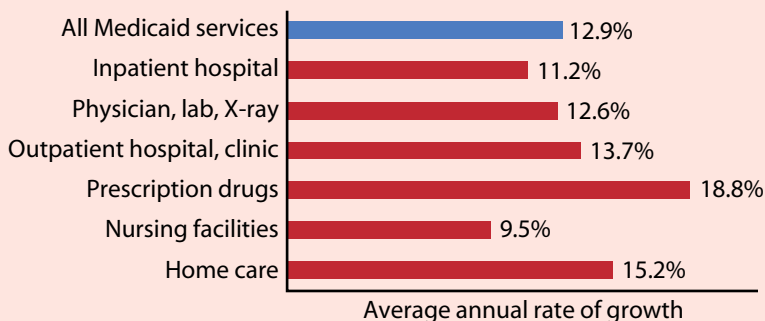
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cision" in the box above), promise to expand Medicaid's fastest-growing budget segment. In 1991, Medicaid spent \$34 billion for long-term care services; by 2002, that figure had grown to \$82 billion (Burwell 2003). Again, the aging of the U.S. population portends even more significant increases in the future.

*Indirect expenditures.* Although about half of Medicaid beneficiaries are in managed care organizations, only 14 percent of total Medicaid expenditures are for services provided by MCOs, because most of those costs are still being incurred by the elderly and the disabled outside of managed care. Another 6.4 percent of the total is allocated for "disproportionate share of hospital" payments, a small price to pay for state gamesmanship and creative financing.

**FIGURE 3 Average annual expenditure growth rate for Medicaid services, 2000–2002**



All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed

SOURCES: BRUEN 2004 AND ROWLAND 2003

### Growth rates

From 2000 to 2002, Medicaid service expenditures grew by 12.9 percent annually. In terms of changes in total fee-for-service expenditures, Medicaid experienced the average annual growth rates depicted in Figure 3 during this two-year period.

### Pressure

Medicaid expansion is increasingly difficult to sustain, because federal revenues are extremely limited and fiscal concerns are growing at the state level. About two thirds of Medicaid spending increases relate to care for the aged and disabled.



In the face of financial concerns at the state level, the most difficult cuts to make will not be in the areas of eligibility and benefits for children but in long-term care and services for Medicare beneficiaries, because that is where most Medicaid dollars are flowing; cutting services to low-income families will yield far less significant savings.

Historically, Medicaid spending growth rates have fluctuated in harmony with then-current sociopolitical and financial factors. Consider the overall average annual Medicaid spending growth rates for the past 12 years:

- 1992–1995: Creative financing generated about a 10 percent rate.
- 1995–1998: Welfare reform decreased spending increases to 3.6 percent.
- 1998–2000: After the impact of welfare reform dissipated, spending growth returned to near-historical levels, at 7.8 percent.
- 2000–2002: Rising health care costs and increasing enrollment drove Medicaid spending increases to about 12 percent, roughly mirroring the increases in private health insurance premiums.
- 2003 (estimated)/2004 (projected): The fiscal situation in the states dictates that spending be reined in, reducing Medicaid spending growth to about 8.2 percent.

### **2010: A health care odyssey**

Medicaid is an expensive program, because it takes care of sick people and buys into an extremely costly and expensive health care system that is challenged to:

- Provide coverage for low-income families
- Reduce the number of uninsured Americans
- Improve access with fairly low per-enrollee costs
- Balance the needs of low-income families against the need to provide acute and long-term care for the elderly and the disabled
- Fulfill its mission despite fiscal pressures at both federal and state levels

Does Medicaid need drastic reform? What are Medicaid's biggest strengths and challenges? If one thing about Medicaid could be changed, what would that be? What Medicaid will look like in 2010 has yet to be decided, but that journey of discovery already has begun.

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## INTRODUCTORY REMARKS

# 4 Perspectives on Medicaid's Present and Future

**M**edicaid is the largest health insurance program in the United States. It is projected that next year, Medicaid will surpass Medicare in both enrollment — 52 million — and spending — \$322 billion. Medicaid not only fills gaps left by other public and private health insurance programs, its reimbursement creates a lifeline for many urban and rural health care facilities in fiscal distress.

*There have been numerous efforts to reform Medicaid to keep it from imploding financially or to avert the prospect of states stripping down Medicaid to a bare-bones structure, but this presents difficult financial and political choices. In this section, a panel of experts collectively evaluate and discuss the challenges of Medicaid and consider what the system should look like in 2010. Their biographies are listed in the order in which they spoke at the symposium.*

**Alan Weil, JD**, is director of the Assessing the New Federalism project at the Washington-based Urban Institute, a nonpartisan policy research and educational organization. The New Federalism project, the largest initiative in the Urban Institute's 34-year history, monitors social programs, policy, and the well-being of children and families for the purpose of providing nonpartisan data to policy makers and the public. Weil coauthored a position paper on Medicaid block grants, which is available online at: «<http://www.urban.org/Template.cfm?NavMenuID=24&template=/TaggedContent/ViewPublication.cfm&PublicationID=8412>».

**Nina Owcharenko** is a senior policy analyst at the Center for Health Policy Studies at the Heritage Foundation, a Washington-based conservative think tank. The center's goal is to find ways to improve health care for Americans through research and innovation. Owcharenko outlined several options for Medicaid last October in a Heritage Foundation position paper, which is available online at «[http://www.heritage.org/Research/HealthCare/wm355.cfm#\\_ftn1](http://www.heritage.org/Research/HealthCare/wm355.cfm#_ftn1)».

**John Engler, JD**, the former Republican governor of Michigan, is president of state and local government at EDS and also its vice president of government solutions for North America. EDS is an information technology company providing applications and business process services, as well as IT transformation services. As chairman of the National Governors' Association in 2002, Engler warned that Medicaid was "the most severe budget crisis facing the states in a decade."

**Joy Wilson** is the health policy director at the National Conference of State Legislatures, which serves state legislators and policy makers by providing them with research, technical assistance, and opportunities for the exchange of ideas. NCSL also advocates for state governments before Congress and federal agencies. The conference has proposed its own Medicaid reform plan, which seeks to increase the flexibility available to states so as to bring innovation to the program. This proposal can be accessed online at «<http://www.ncsl.org/statefed/health/marefprop2.htm>».

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# We Ask a Lot of Medicaid But Don't Fund It Accordingly

Alan Weil, JD

**M**edicaid's biggest problem is the mismatch between what we ask the program to do and the resources we devote to it. In this country, where we have not seriously considered universal health care, and where long-term care and its financing are fragmented, Medicaid is left with a broad range of responsibilities.

Of Medicaid's expenditures, 43 percent are accrued by people with disabilities (Crowley 2003). Medicaid pays for a tremendous range of conditions and circumstances: serious and persistent mental illness, traumatic brain injuries, HIV/AIDS, degenerative diseases, and developmental disabilities. It's an essential insurance program that covers people who would have otherwise been in the middle class but who face either a health condition or declining health in old age. Medicaid is there for them.



**States design and run** Medicaid uniquely, according to their own conditions and circumstances. This is a source of innovation and creativity — something I do not propose that we change.

— Alan Weil, JD

Despite the fact that Medicaid plays the fundamental role of a social insurer in this country, we still pay for it as if it were a welfare program. We make it a last priority, we talk about it in public debates as a welfare program, and we don't treat it with the same understanding that we do other major social insurance programs in the country. So, the first problem with Medicaid is that we ask it to fill huge gaps in our health care system, but we fail to pay for it accordingly.

The second problem with Medicaid is that the states are large financiers of the program. The fact that the states design and run Medicaid uniquely, according to their own conditions and circumstances, is a strength of the program; it's a source of innovation and creativity — something I do not propose that we change. Nevertheless, states do not have the revenue-raising options that the federal government has. Many have overwhelming balanced-budget requirements, unlike the federal government. So when states face such trends as economic downturns, the current demographic change, or new medical conditions and their cures (all of which add to the cost of Medicaid), they are not poised to ride smoothly through those trends.

Along with the heavy burden we place on Medicaid, we place a heavy financial burden on the states. If we want this program to continue to play its current role, we have to expect the federal government — with its federal tax base — to carry a larger share of the financial burden.



**States have expanded** Medicaid coverage to include new groups of people with relatively higher incomes; the question is now whether we are spreading Medicaid too thinly.

— **Nina Owcharenko**

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## Realigning Medicaid Means Realigning Incentives

Nina Owcharenko

**I**t is important to see Medicaid as one element of our entire health care system and to consider all the elements and their various roles. Medicaid fills a gap in our system; it is a safety net. Yet Medicaid should not be considered a solution to the problem presented by such gaps.

My focus is on three principles relative to Medicaid. First, there is a need to reevaluate its focus, which is to provide health coverage for people who have no other options. Medicaid thus provides an important service. States, however, have expanded Medicaid coverage to include new groups of people with relatively higher incomes; the question now arises as to whether we are spreading Medicaid too thinly. State budgets are tight, as is the federal budget. The federal government may not need to balance its budget, but its resources are limited by Americans' unwillingness to pay high taxes. Thus, while Medicaid provides an important service, financial resource limitations mandate that we consider refocusing it.

Second, if we are going to refocus Medicaid, we need to change its incentives — which, as they are currently, are bad. The present system is inefficient, which leads to the third principle: Medicaid should be patient-centered, not system-centered. Currently, Medicaid is based on the systems involved, rather than on patient care and outcomes.

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## Primary Policy Considerations: Funding and Flexibility

John Engler, JD

**M**edicaid is too big to be allowed to fail. Medicaid is every governor's biggest budget concern. It's the fastest-growing part of state budgets — surpassing education, in some states, as the biggest budget item. It's also been the most problematic item for states, financially; now that states are experiencing some financial growth, almost all of it is consumed by the increasing cost of Medicaid. Medicaid has been so popular that we have built a whole industry helping people spend down<sup>1</sup>: If they don't qualify for Medicaid now, we make sure they will. So, Medicaid needs drastic reform.

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<sup>1</sup> *Spend down* is a provision that enables a person to qualify for some Medicaid assistance even if that person's income or assets exceed Medicaid eligibility standards. In states that have established "medically needy" programs, children, people with disabilities, pregnant women, and the elderly whose family income exceeds the established income limit for Medicaid may yet become eligible for assistance by spending the excess income on medical bills — "spending down" the difference between their income and the income limit to become eligible.

Let's attack the problem of dual eligibles (people who qualify for both Medicare and Medicaid) first (Figure 1). Medicaid has bailed out Medicare. I think Medicare, as a system, is extremely fortunate to have had Medicaid shoulder its heavy burden for so long when it comes to pharmaceuticals. When it comes to dual eligibles, it is essential to sort out who is responsible for which population. I don't like shared responsibilities; when more than one level of government is in charge, nobody is really in charge. That's the situation with the elderly population today.

Not long ago, we had some success with the dual-eligible cost structure. We rolled dual eligibles into some of the same managed care structures that were involved with Medicaid, but the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) told us we couldn't do that. I suspect there was litigation along the way. In fact, in discussing Medicaid today, we must remember that a federal judge might rule on these issues. The current policy has been formed with judicial help, in terms of expansion and additional cost. The overall trend has been to open Medicaid's door more widely. Inevitably, that comes with a price.

Earlier in this forum, Alan Weil talked about the federal government being unwilling to adequately fund Medicaid, which is clearly an issue. The 6 percent on disproportionate share of hospital (see Rowland, Figure 2, page 5) doesn't look like much money, but it sure helped the states. There was a conscious strategy on the part of states to read carefully what the federal law said, in an effort to fully understand it. We said, "You tell us what the rules are, and then we'll play the game." Often, after we had read the law and tried to understand the rules, Congress told us we were playing the wrong game, and that it had actually meant something else when it wrote the law. "It's not what we said, but what we meant," Congress told us. There has been a great deal of confrontation relative to this problem.<sup>2</sup>

Some of that confrontation would dissolve if we could just clarify who is responsible for what population. It was proposed, in the 1980s, that the states should take responsibility for families and children, and the federal government should take responsibility for long-term care and the Medicare population. Then the federal government could set its policy and pay for it, and states could do the same. At least, then, we would be logically separated.

In 1995 and 1996, Congress approved plans to convert Medicaid to a block grant. The bill went to the president's desk but did not get signed. It actually passed Con-

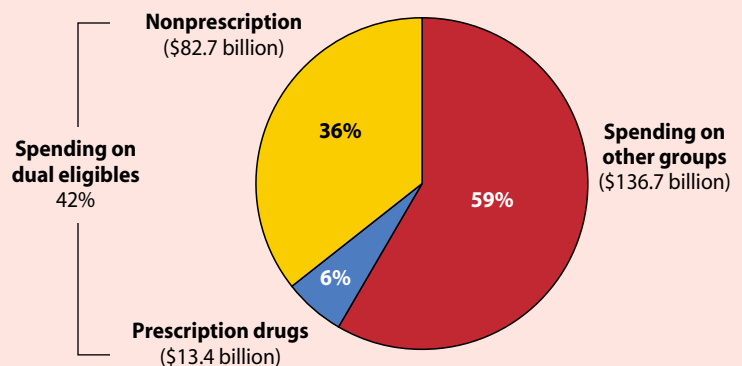


**"Some of the confrontation** [between the states and the federal government over Medicaid] would dissolve if we could just clarify who is responsible for what population."

— John Engler, JD

**FIGURE 1 Spending on dual eligibles**

As a share of Medicaid spending on benefits, federal fiscal year 2002



**Total spending on benefits = \$232.8 billion**

SOURCE: URBAN INSTITUTE 2002

<sup>2</sup> Disproportionate share of hospital (DSH) payments are additional payments in Medicare and Medicaid programs that help hospitals recoup costs of uncompensated care to low-income patients. Medicaid DSH payments have been a subject of controversy because states have been able to use intra-governmental transfers to finance the state share of DSH to state-owned hospitals. Sensing that states — which used this latitude to cover Medicaid budget shortfalls — were short-changing private hospitals, Congress passed legislation in the 1990s to limit such discretion. This has had the effect of sending more DSH money to private hospitals but has increased the financial burden on state Medicaid budgets.

gress on a couple of occasions, but in the final compromise on welfare reform, Medicaid block grants were dropped. We were so desperate that we said, “Look, let’s set aside a block of money, and you give us the flexibility at the state level.” It didn’t happen. But flexibility is still important, because the mandatory population and mandatory benefits are actually just a small part of Medicaid.

Now, it’s customary today (and some federal judges think it is their right) to rule that the mandatory population should be bigger than the federal law ever anticipated and that the mandatory benefits should be broader. Yet, if the mandatory population and benefits were not written into federal law, states could have more flexibility and would be able to structure and manage their programs without need for waiver or review. I would not have thought this was so significant, but with the severe budget downturn in the last couple of years, some states reduced Medicaid benefits. Some governors and legislators reached a level of desperation that made them do what I never thought they would do. Giving states more flexibility would improve incentives.<sup>3</sup>

Then, when welfare reform was done at last, we (states) thought it would help people go back to work, which would make more money available to us. We also thought we might use the Temporary Assistance for Needy Families (TANF) grant money as a rainy-day fund. Then we decided, however, that we probably could not trust Congress to leave that money and that we should not allow our accounts to grow too large. Congress also decided that it could not trust us, so it added a “maintenance of effort” requirement, forcing us to keep spending money. Child care became a popular expenditure; child care expenditures went right through the roof. Maybe Congress’s decision was logical and necessary, but some of that money could have served as an offset against health care expenditures, which were clearly predictable.

When you hear governors and state legislators testifying in Washington, saying, “Please give us more flexibility,” these are the kinds of issues they’re talking about. I think we are at a point where states don’t have enough flexibility to bridge Medicaid’s financial gap: the gap between what is expected of it and our ability to pay for it, especially considering the dual-eligible population and the cost of psychotropic therapies.

So, there are some fundamental questions about what Medicaid should be in the future — questions that we need to ask today. We can examine the need for flexibility, which is the perspective that I bring. Nevertheless, those who are seeking simple answers to the problems being discussed here will find that the complexity of this subject means that simple answers remain elusive.

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<sup>3</sup> President Bush has proposed converting Medicaid to a block grant structure but does not refer to the recommendation as a block grant. The administration proposes to give states “significant flexibility” to spend “lump-sum allotments.”

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# An Optimistic Perspective: Medicaid as Cinderella

Joy Wilson

Medicaid is like Cinderella before the ball. Two ugly stepsisters — Medicare and the employer-based system — unload on Medicaid. Poor Cinderella scrubs the floors and does all the tough jobs but gets none of the money. Cinderella's strong, and she's working hard. I have dreams that one day Cinderella will get to the ball, but we will have to work hard to get her there.

Medicaid is not given sufficient resources to do all that we expect it of it. As states, we facilitate this, in a sense: We play games with the federal government; but, in the end, nobody wins. We have limited revenue-raising ability; education consumes 50 percent of most state budgets, and Medicaid consumes between 15 and 20 percent, depending on the state — which doesn't leave us with much money to pay for everything else. So, it is a continuing struggle.

On May 6, the Senate passed another new optional Medicaid service for families with disabled children — the Family Opportunity Act.<sup>4</sup> We continue to get new options, and we want to fund programs at the state level. We want to help people, but our money is tight right now. So we're having to retract, and that's a terrible thing, because to cut costs, we only have a few options: we can lower payment rates to providers, we can cut services, or we can cut eligibility.

Our ability to cut costs is limited partially by politics and partially by reality. If we reduce reimbursement to the point where providers don't want to participate, then we have a Medicaid program in which nobody is providing services. If we cut services back too much, then we are not really providing medical services to our population. If we reduce eligibility, we hurt our chances of being reelected. There are groups that we don't want to exclude, politically or otherwise. The groups that cost the most, like the disability community, have become aggressive and successful lobbies, as well they should. They need services, and we don't provide many options outside of Medicaid to take care of them. Politically, then, it is hard to find savings in Medicaid.

Does Medicaid need reform? Absolutely, and one of its problems is financing. Anyone who has spent any time working with Medicaid knows that Congress provides funding to states according to a formula that is partially based on per-capita income — and also knows that we almost never talk about the Medicaid formula. Why? There *is no* formula to make things run smoothly and win votes, too. Nevertheless, it is hard to talk about changing Medicaid's financing without talking about the current formula.

We know what our problems are, but it's hard to initiate a conversation. In the past, when we've talked about Medicaid reform, it hasn't been in the context of providing marvelous health care services for Americans. Instead, we've talked about how tight the budget is and how we need to clamp down because the program is grow-



**Congress provides** funding to states ... but almost never talks about the Medicaid funding formula. Why? There *is no* formula to make things run smoothly and to win votes, too.

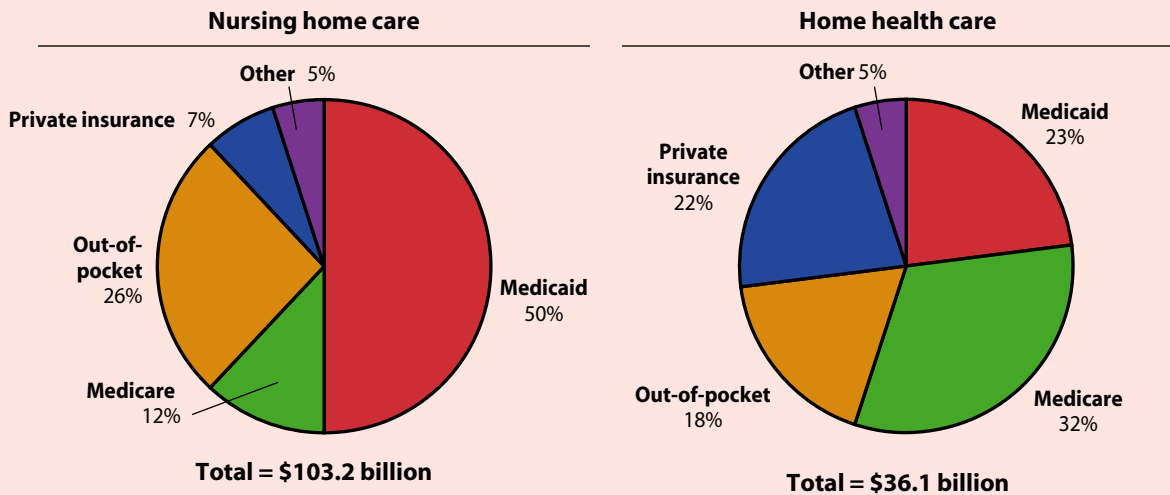
— Joy Wilson

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<sup>4</sup> As of July 29, 2004, the House version of the act, HR 1811, was stalled in a subcommittee of the House Committee on Energy and Commerce. The outlook for enactment of this legislation is unclear.

**FIGURE 2 National spending on nursing home care and home health care**

Fiscal year 2002



SOURCE: LEVIT 2004

ing too fast. When we talk about reforming Medicaid by shrinking the program and, at the same time, try to fit more people and more services into it, conversation becomes difficult.

Long-term care is another challenging issue, particularly in light of the fact that it isn't just people with low incomes who get the nursing home benefit. Everybody who has an aging parent knows to go to the yellow pages to find help getting that benefit. There have been some efforts to rectify this, but, politically, that's difficult to do because we have no alternative to offer. We need to take a hard look at this issue, because given current demographics, I don't think we can sustain that part of the Medicaid program (Figure 2). Certainly, our role in taking care of dual eligibles needs to be addressed. We also need to recognize that our employer-based system is no longer doing the job it once did. We have to decide whether we can maintain such a system, and if not, to determine what we will do instead. We are not having a conversation about that — yet we must, because Medicaid is the Cinderella: She takes care of everything that falls through the other systems.

Many challenges exist, but I have been doing this a long time, and I remain optimistic. I think Cinderella will get to the ball in my lifetime, hopefully in a way that will improve health care for a broad range of people in America. In my dream world, Cinderella goes to the ball. She's not considered a welfare program — not *that* program. In my dream, Medicaid is a mainstream program providing health care, a premier program, as popular as Medicare, and no longer the long-suffering servant. That's what I hope for.

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## ROUNDTABLE DISCUSSION

# The Future of Medicaid: Where Do We Go From Here?



**A**s medical technologies and population needs change, the Medicaid program — the largest body in the health care system — also must evolve. After their opening presentations, panelists (above, from right) Joy Wilson, John Engler, JD, Nina Owcharenko, and Alan Weil, JD (see biographies on page 8) examined the program’s future role and functions. Diane Rowland, ScD, executive vice president of the Henry J. Kaiser Family Foundation and executive director of the Kaiser Commission on Medicaid and the Uninsured (standing at left), moderated the discussion.

Rowland opened the discussion by asking panelists to name a single change that would most improve Medicaid — excluding, as Weil clarified, “writing an unlimited check out of the federal treasury.”

**DIANE ROWLAND, ScD:** We’ve discussed the numerous holes in the structure of health care and our society that Medicaid is asked to fill, and the expectations versus the reality of financing. We’ve heard about differences between federal and state governments with respect to who governs what and how, and how money flows. So, if you could change one thing in the program, what would it be?

**JOY WILSON:** I’d change the way people view Medicaid. Aside from those who realize it’s the only program that is paying for long-term care, most people in need of acute care services are not looking to Medicaid. A major step forward would be to structure it as a more mainstream program that people would consider to be high quality and would support, as we’ve done with the Children’s Health Insurance Program (CHIP).

**JOHN ENGLER, JD:** I recognize that it’s 2004, that the Health Insurance Portability and Accountability Act protects your medical record, and that you have a right to control your record and your privacy. With that privacy, I’d get records into

an electronic format so we have an e-record and e-prescribing, and then, when we go to public-funded health care sections of Medicaid and Medicare, we could do things that logically flow from that. We'd eliminate mistakes in filling prescriptions, and in the emergency room we'd find out about allergies to medications or tests that have just been administered. We wouldn't have children receiving repeat immunizations because of someone who hasn't kept the records right. We could take an awful lot of waste out, catch fraud, eliminate medical error, and clean up health care administration. Plus, from a consumer perspective — and this is where the government can use its leverage as a big purchaser — we need to drive outcomes through better measurements.

We could say, for example, that Philadelphia is an area that may have excess hospital-bed capacity. If there were extra beds here, which ones would you take out and why? You might look at where the best results are — in which facility are you getting better treatment for heart ailments, for example? I might take out the least effective program instead of trying to run two programs of medium quality. I would go through and begin to rationalize changes, but I would do so based on quality-of-care data. If providers didn't want to do that, they could play a pat hand, but purchasers ought to be able to make informed decisions to say, "I'm going to buy all my heart treatment for the



**"Medicaid has been a tremendous innovator in meeting the evolving needs of people with chronic conditions as those conditions have changed with time, as our treatment patterns have changed, and as the role of pharmaceuticals has changed. There is no other payer with as much experience in and understanding relative to the complex needs of populations with long-term and chronic conditions."**

**— Alan Weil, JD**

Medicaid population *here* — where outcomes are twice as good as they are over there," and then we'd see what would happen in the market; the other place would either improve or disappear. Reward for performance is an incentive that ought to be present in health care. Then, economic awareness grows, because we can tell people much more about their health care budget. Once they have an understanding of their health care budget, we might be more successful with prevention. That's another big question that must be addressed at some point, if we are to beat rising health care costs.

**ROWLAND:** Your reforms speak to what we need in our whole health care system.

**ENGLER:** You can't solve Medicaid in a vacuum; it's the biggest part of the health care system. In many ways, the government ought to use Medicaid, Medicare, and its own Department of Defense/Veterans Administration and government employee programs to drive reforms.

**NINA OWCHARENKO:** What I'd most like to see is more communication between states and the federal government. With respect to reforming the program, a big problem is the lack of interest from Washington relative to addressing the Medicaid problem head on. In particular, the debate about Medicare has taken steam from looking at Medicaid, which is actually more costly than Medicare.

The Bush administration brought a reform proposal to the table that evaluated separating long-term care from acute care — funding them separately, so you could get at the crux of the program. So, instead of having one large program covering it all, you'd start delineating where funding would go and attempt to get better outcomes. Unfortunately, the proposal seems to have fizzled out, but that debate should be renewed.

**ROWLAND:** As we talk about splitting acute and long-term care — and having one level of government do one thing and one level do another — it goes back to Joy's earlier comments. There is so much difference between the states, in terms of what they

are doing. We'll have many losers unless we spend a considerable amount of money to buy out some of the existing responsibility. It still comes down to dollars.

Alan, why don't you give us your fix?

**ALAN WEIL, JD:** I wanted to begin by objecting to the question, because it's framed as if there is something we need to do; nonetheless, my colleagues have already answered, so I can't object. The varied answers already given suggest that, first of all, it is difficult to talk about what needs to be done in the Medicaid program without discussing what needs to be done in the health care system as a whole. At one level, we want Medicaid to be a leader, and in many respects it has been; it also has to be a follower, because there have been tremendous changes in the health care system since the program was created.

I would begin by separating long-term and chronic care and establishing what it means for us, as a nation, to attempt to finance and meet the service needs of chronically ill people. In fact, Medicaid has been a tremendous innovator in meeting the evolving needs of people with chronic conditions as those conditions have changed with time, as our treatment patterns have changed, and as the role of pharmaceuticals has changed. There is no other payer with as much experience in and understanding relative to the complex needs of populations with long-term and chronic conditions.

I think, however, that we've lost the sense of how complex this problem is, how Medicaid fills in for Medicare, and how Medicaid makes it possible for much of the private-employer system to function. For example, when commercial policies were first adopted, a coverage limit of \$1 million seemed like more money than anyone could ever spend. Today, it's not more money than anyone can spend, and Medicaid becomes the payer above that amount. Medicaid also provides coverage for someone who needs a customized wheelchair, intensive therapies, or longer therapies than a traditional commercial plan would cover. We've pulled many high costs out of Medicare and the employer system.

If I could do one thing, I'd take a look at these high costs across populations and try to determine who should really pay for this. If we fixed that problem, Medicaid would be in a better position to meet the acute care needs of mothers and children who constitute the bulk of the program; it would be a more manageable program, but we also would have a more honest discussion about the increasing demands on the health care system due to chronic conditions.

**ENGLER:** There is an excellent Michigan Commission on End of Life that wrote a marvelous report; if we take long-term care costs and look at how many of them occur in the last six months of life, we see a disproportionate amount. The hospice movement has been important, but determining what more ought to be done there — and the area of death and dying in general — is extremely challenging. How do we handle drug therapies to make sure people are comfortable and avert the need for hospitalization? We have much more flexibility with hospice, but even more can be done. That is an area where figuring it out can be not only humane and compassionate, but also tremendously cost-effective.

## QUESTIONS FROM AUDIENCE

*Panelists responded to questions from the audience, as posed by Rowland.*

**ROWLAND:** There are two questions concerning covering the uninsured and moving toward universal coverage. The first question asks, "In a single-payer system, what would Medicaid's place be — or what would be left for Medicaid to do?"

The second is, “Why not end the multiplicity of programs and have governors endorse a federal single payer national health insurance program?”

**WILSON:** Our current policy says to take away Medicaid, but I don’t think that’s going to happen, partially because states are putting in so much financing. To suggest that the money somehow would not be required to remain within the system is probably not realistic. Also, if we are going to make that kind of investment, we will want at least *some* say in how the money would be spent.

**ENGLER:** Well, there is a part of me that likes the idea of making all doctors public employees and putting trial lawyers out of business by extending immunity to cover public-employee doctors; that would remove all the litigation cost from the

health care system and allow us to put it back into care. But, to the question, I was a governor in a state on the border of Canada, whose single-payer system is sometimes held up as a good example. It’s not even close to universal care, though, and if you are in Canada and need urgent care, you come to the United States. Those who can afford it come here, and everybody else waits in line for their elective surgeries.

I don’t think Americans are seeking that kind of system. I’m not convinced that it’s much cheaper, and I’m certain it’s not considerably better; it’s not even close to being as good as the system we have. Governors, as a group, have not thought that a single-payer system makes a good deal of sense, and lost in all this is the tremendous amount of innovation that has come out of American medicine, on both the research and the discovery sides — everything from medical

tools to pharmaceutical treatments.

**ROWLAND:** Here’s a question with a slightly different take. “Given the dramatic rise in cost that is focused on disease treatment, when do we begin to look at providing coverage for the uninsured to work toward prevention? Do we need comprehensive coverage for some, as opposed to basic coverage for all?”

**OWCHARENKO:** That’s the fundamental question causing much conflict when we discuss covering the uninsured, because you have to define what *covered* means. At a time when people find coverage policies unaffordable, you can have some health insurance policies that cost up to \$10,000 per family. We have to be practical and realize that sometimes what people really need is coverage for preventive care — to make sure they go to the doctor — as well as coverage for a catastrophic event.

Yes, there will be some people whose needs won’t quite be met, and so there may need to be a safety net via the Medicaid program. I would propose having people make their own decisions about the type of policy they want — such as whether they want Cadillac plans that pay for everything from seeing a doctor for a cold to surgery — and then help them by directing the government’s limited funds toward financial assistance. If they can’t afford a copayment, then let the states and the federal government figure out a way to help.

**WEIL:** I’m going to try to integrate those last two questions. With respect to the first question, on the role of Medicaid relative to providing coverage for the uninsured, it probably decreases as long as the single-payer system includes long-term care.

I am not a fan of a single-payer system, though for different reasons from Gov. Engler. I have a hard time feeling enthusiastic about how the American political



**“We have to be** practical and realize that sometimes what people really need is coverage for preventive care — to make sure they go to the doctor — as well as coverage for a catastrophic event.”

— **Nina Owcharenko**

system is going to allocate a seventh of the American economy. A recent report from the Medicare Payment Advisory Commission, which is appointed by Congress and not exactly a left-wing organization, said the average payments for HMOs in Medicare are 7 percent higher than what they'd be for those same services through the traditional fee-for-service Medicare program.

Why do we pay more to managed care companies than we do to the fee-for-service system? It has something to do with the American political process. To have that same process allocating all the health care resources in this country, with as many problems as the current allocation system has, would be worse.

There are many paths you can go down in discussing coverage of the uninsured that I think we shouldn't go down. I was in Denver on a panel with former Colorado Gov. Lamm, who became famous for the "duty to die" phrase, and — low and behold — he is still talking about the inability to pay for everything for everyone.<sup>1</sup> At one level, it is obvious that we can't afford everything for everyone, but we need to stop believing that the phrase has any meaning.

The real question is, can we afford a comprehensive set of health care benefits and coverage for all Americans within the most wealthy and powerful country in the world, spending almost twice as large a share of its economy on health care as any other nation — including dozens that provide insurance to everyone. It seems to me that suggesting we're going to solve this problem by not giving enough to those who really need it is the wrong way to start this discussion.

We know that a lot of money is not spent well in the health care system. It may be spent on administration, but more importantly, within delivery of health care, we have solid reports from the Institute of Medicine and elsewhere showing that we have wasteful or ineffective procedures. The allocation of resources within the system is so poor that the notion of getting to universal coverage by scaling back benefits seems wrong. We could get somewhere if we started with the notion that, of course, there's enough within the system and within this country to do the job; how do we do it in a cost-effective way, an equitable way, that doesn't put financing burdens on those who can't bear it — including state and federal treasuries?

**ROWLAND:** I think you've just answered the next question: "Wouldn't it make more sense to outlaw profiteering in health care and pharmaceuticals than to deny medically necessary care?"

**OWCHARENKO:** The question becomes, "Shouldn't people who can afford it pay their fair share, so we can direct the limited resources to those who can't pay the cost of a medicine at fair market price?" Should we be looking to help them instead of, as the question alludes, bringing the prices of drugs to one price so everyone pays the same amount, because it's low and cheap? Should we instead look to direct our limited funds toward people who need it and therefore allow the system to grow?

**WEIL:** Well, within limited resources I would generally agree with you, but let's con-

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<sup>1</sup> Richard D. Lamm has spent more than 20 years warning America that slowing birth rates and growing life expectancy are rapidly rendering the social contract built around Franklin Roosevelt's New Deal and Lyndon Johnson's Great Society unsustainable. Lamm argues that Social Security and Medicare are fiscally untenable — as well as morally indefensible, transferring vast amounts of wealth to today's elderly at the expense of future generations. In an interview with *MANAGED CARE* that appeared in the August 2002 issue, Lamm warned that rationing resources, however, is more than just an exercise in blunt force, and suggested that policy makers have not thought through the implications of rationing. The interview is available online at: [http://www.managedcaremag.com/archives/0208/0208.qna\\_lamm.html](http://www.managedcaremag.com/archives/0208/0208.qna_lamm.html).

trast Medicare and Medicaid instead of this abstraction. Medicare is universal. That means we spend money on people who don't need help, while Medicaid is means-tested; you can't get on it unless you are poor by some definition — and the definitions vary.

Which of these programs is more customer-friendly, which has better public buy-in, as a whole? Which of these programs makes better use of administrative dollars? We are about to try an experiment that I am glad I don't have to administer, which is to begin means-testing in Medicare, because the new prescription drug benefit is means-tested.

I want to see how Americans' view of Medicare changes as a result of this. So, in theory, should you target limited resources at those who have the least? Absolutely. Do you undermine the very things you desire when you make it a welfare program, which is the definition of a means-tested program? In practice, we find that we do. It's not as easy as just wanting to target those who need it most.

**ENGLER:** With CHIP, though, we found children without health insurance in families that were Medicaid eligible — but to get CHIP coverage, the family was required to enroll in Medicaid. Some families responded that they would rather go without coverage. It is an interesting phenomenon.

With Medicare, you've got an entitlement program of a different type. People rationalize by saying, "Well, they didn't ask me my income." Yet, in a sense, it's just a different name for a program. I'm thinking in terms of how you bring Medicare and Medicaid together, and Nina's point is an interesting one — that we should at least look at how the programs intersect — bringing us squarely to the dual-eligibility issue. Some people say that because Medicaid is limited in its benefits, because it sweeps so widely, they have to pretend they're somebody else to get into this program that they were never intended to be in.

If there was a way to give people a health budget at some point and put them in charge of it, interesting decisions would be made. It's difficult to do that with older people, because they're going to have expenses; but it's tough to sell the concept to younger people, too. We tried it in negotiations with state troopers, a group of pretty fit people, and they said, "Something's wrong with this. I don't want to run the risk." They could have put thousands of dollars in their pocket, instead, they chose to pay the insurance premium and keep their existing coverage.

## **BUDGET ISSUES**

**ROWLAND:** We have a question that asks why Medicare does not cover all treatment costs for those who are above age 65, rather than dividing these costs between Medicare and Medicaid.

This is a budget issue, and when Medicare was enacted, it was enacted for everyone as a limited benefit. The view was that Medicaid would be expanded — beyond just taking care of the aged and disabled — to some of their long-term care, to wrap around Medicare. That wraparound has been how the federal government has managed to hold its Medicare costs down all these years — and why, in the drug bill, you saw a tremendous battle between the states and the federal government over assuming that dual eligibles get drug coverage through Medicare, and why states now have to reimburse Medicare for a large share of that. To a great extent, we formulate policy in Washington by budget, as opposed to what makes good sense.

**WILSON:** Congress seems to feel that those who receive Medicare benefits are more

important constituents than those who are enrolled in Medicaid. By shifting some costs to Medicaid, you can keep the Medicare constituency happy without having to sacrifice from the federal side, but then the states have to figure out how to make that work. That's the political magic that is done in Washington, where the government continues to shore up whatever it thinks is most important.

It's interesting that there are now some members of Congress who find Medicaid is an important issue with important constituents. That's why I have some hope for Medicaid, but it is not often talked about.

**ROWLAND:** This question is, "How might a state responsibly engage with a policy to limit benefits to establish a safety net while limiting expenditures?"

**ENGLER:** Let's start with a broad view and then narrow it to pharmacy. Utah was an example where then-Gov. Leavitt wanted to blend a concept of providing additional coverage to some of the lower-income uninsured. Instead of providing a Medicaid benefit mandated by law that was, for Utah's standards, a sport-utility vehicle, he wanted to reduce it to a compact vehicle and then use the savings to cover additional people. He wanted to harmonize that across the population, and he was told for a long time he couldn't do it. In the end, I think he received limited approval but not what he really sought.

On the pharmacy side, specifically, we are again seeing states take unprecedented action, such as joining together to purchase drugs on a multistate basis. We're seeing some states try to save money by establishing one drug in a class as the preferred product, either by experimenting with reference-based formularies or choosing with what they believe to be a pharmacologically equivalent generic drug; patients pay more if they want another generic equivalent or a brand-name drug. General Motors, Ford, and Chrysler recently indicated that they are going to a consistent mail order approach on all their pharmacy, arguing that patients with chronic diseases can get a three-month supply at a time with only one copayment rather than three in three months. All of these are examples of how states are dealing with pharmacy challenges and attempting to stop fraud and prescription abuse.

**WILSON:** The Medicare bill didn't help much on the pharmacy side, because under the new law Medicaid is not going to get the best price. We get neither the Veterans Administration nor the Department of Defense prices, and the 340B price does not count.<sup>2</sup> Anything negotiated under the Medicare bill doesn't count.

Also, many states are looking at supplemental rebates as a way of helping to lower cost for their prescription drug programs. But we use the dual eligibles — our high prescription drug users — to help us gain leverage in those negotiations. We no longer have those people in our portfolio, but we are still paying for them. That kind of thing sets us back in our efforts on the prescription drug side. Not to say that things like formularies and pharmacy benefit managers won't help, but certainly we are climbing up the hill — and somebody is pouring water on us from above — making it a little difficult.



**"There is a huge opportunity with mental health. The key is to put money into the community [as opposed to institutionalization] — and frankly, by doing this, you are going to improve care immediately in almost all cases."**

**— John Engler, JD**

<sup>2</sup> Section 340B of the Public Health Service Act limits the cost of drugs to federal purchasers and to certain grantees of federal agencies. See «<http://bphc.hrsa.gov/opa/Section602.htm>».

**OWCHARENKO:** I wanted to touch on what Gov. Engler had talked about, with respect to what happened in Utah with ideas of greater flexibility. The catch is that you have to expand coverage to get flexibility. It's almost inevitable that you end up cutting benefits. If you want incentives, you need to read what your current package is offering. You shouldn't be forced then to add a greater burden to the program you already have, which is the pickle that many states got into.

On the pharmaceutical side, I want to highlight something we saw in Florida. The state teamed up with a pharmaceutical company to look at how to care for a person as a whole, meaning all the conditions that a person is facing. So, instead of just saying, "Here's a pill," they said, "Let's look at drugs in *this* category, and let's look at hospitalization in *that* category, and physician services in *that* one." I believe they have had quite a bit of success with that approach.



**"We need more trust** between the states and the federal government; without that, we cannot move forward. We are always looking over our shoulders at each other now, and you can't really proceed with that kind of relationship."

— **Joy Wilson**

## **OUTSOURCING, MANAGED CARE, AND SOCIAL ISSUES**

**ROWLAND:** We have a question about whether states' outsourcing the Medicaid program to private insurers is a way to go.

**ENGLER:** I think there are some good experiences with that. California does this to an extent; Colorado has a new system that is about to go online, with some potential big savings. Claims processing is almost a commodity type of task. In the future, you will see multistate collaborations.

The Centers for Medicare and Medicaid Services is trying to drive similarity between states and the different claims-processing systems. Right now, it's a competitive market of no more than four or five good-sized companies — EDS

being the largest, ACS probably being second in the market, followed by Unisys. Some significant value can be brought out with this approach. There is logic to doing it, and it keeps technology fresher.

That's an area in which there is a good value proposition in some states, while others need to take a look at it. Frankly, I'd say that the federal government ought to insist on this, because it is paying for part of it — but the governor also ought to insist.

**WEIL:** Gov. Engler focused on administrative outsourcing, which may be what the questioner had in mind, but administrative costs represent a small percentage of the Medicaid program's expenses. Relative to the broader question of outsourcing, it's really on the delivery-system side.

With my colleagues at the Urban Institute, I looked at the experience with managed care, which is the quintessential outsourcing within Medicaid. It probably spread across states too fast, in that there wasn't enough time to learn how to do it right. Nonetheless, the learning improved with time, and although the portion of cost associated with managed care contracts is fairly small, the percentage of the population enrolled is quite large.

That example tells us both the pros and the cons, because we've observed that, around the country, states went to managed care for a combination of reasons, including cost savings and access improvement. When states got to managed care and budgets got tight, they squeezed down on their handful of managed care contracts, thereby removing whatever ability those plans initially had to redirect



money and invest in information technology and the kinds of true care management that's positive for patients. So, there was a risk of killing the tool that was supposed to be successful.

**ROWLAND:** We actually have a question about whether enrollment in managed care is a strategy that states should pursue more broadly for dual eligibles.

**WILSON:** I'm going to jump ahead and say yes, though I say this with a great deal of caution. Before the premise of managed care became the negotiation of better rates, it was to save money by moving services to prevention and reducing institutional care, particularly hospitalization. We do have such models for the typical population; we have far fewer such models for a more medically complex population — a population that needs more social and medical services.

Also, the group of Medicaid enrollees with disabilities, which makes up almost half the program, is incredibly heterogeneous. To say we are going to offer managed care for people with disabilities means little. The issue is whether you have a care model that works for people with severe and persistent mental illness. With that, there may be something you can do about the delivery system. If we are going to talk about managed care for the more extensive population, however, we need to acknowledge the complexity of the population and the need to tailor delivery systems to specific needs.

**ENGLER:** There is a huge opportunity with mental health. I'm amazed at the legacy institutions that are still operating in some states, where you have an institutional population that's dropped, in some cases, below 100, though the sense is that there are perhaps 200 employees working there. There may be a politically connected union representing those employees, but the key is to put money into the community. Money has to go to the community — and frankly, by doing this, you are going to improve care immediately in almost all cases. Another phrase is de-institutionalization, but that's been given a bad rap — in part due to mental health code changes, which ended the involuntary-commitment debate about how to deal with someone who is no longer accepting treatment. We should be beyond just locking people up.

Another area of concern on the administrative side is that many states have large correctional facilities, which lends itself to some hospital networks' advantage; for them, that's a good business with which to be working on an outsource basis, as opposed to in-house in the state. In some cases, where that had not been done, hospital networks are carrying high costs to staff a prison. It ought to be done differently.

**OWCHARENKO:** I also think that the managed care model is outdated, in terms of keeping costs down, as opposed to the case management model. In some states, we see that they are not only doing case management, but they also are allowing people to direct the resources they get through the program to the services that they want, so that they buy into the system. Therefore, it is not, "These are the services you get under this program — now, use them." Instead, they are able to pick and choose. I think we can learn some lessons, particularly on the service side, about the benefits they get outside of the health area.

**WEIL:** Managed care was supposed to manage care and save money, but the managed care part got lost in the shuffle. Now we're talking about disease management as if it were a new discovery. It was always supposed to have been part of managed care, because we were going to have everybody who dealt with the patient feeding information into a single site — but you know how things happened.

Now we're approaching that again, and in looking at chronic illness, we pick up some dual eligibles. We're not talking about disease management for just diabetes or just cardiovascular conditions, but we're looking at trying to manage those people who have chronic illnesses.

**ROWLAND:** We have a few questions that get into that point, given that many chronic and other diseases have lifestyle and behavior components. Can Medicaid be a leader, or does it lag on those issues? How can Medicaid move beyond the medical model, in which it often gets stuck, to respond to some of these broader social issues?

**ENGLER:** Part of the answer is to be found in how governors and state legislative leaders view their management. We ultimately concluded that we needed to have what we called a community health agency. In it, we put what formerly would have been the Department of Mental Health, the Department of Public Health, and the Medicaid program. We then said, "This is about community health, what might be wrong with it, and how to get it fixed."

In the public health department, for example, when we were talking about MCOs or the case management approach, we asked why we should be paying for the traditional public health immunization clinic if the population is in a managed care program. That suddenly gets at somebody who says, "Wait a minute; I do that." Nevertheless, trying to redefine these roles and to rethink how you get at who does what in a new system is important.

That's how you get at such issues; you need to redeploy your personnel. For example, teen pregnancy is a health care issue. Clearly, if the incidence of teen pregnancy goes down, that affects many social costs relating to health care costs. That's a very powerful measurement.

**OWCHARENKO:** It also seems that, as you mentioned, reducing teen pregnancy is a tangible measure. People can see how they're doing with it, and if they're not meeting their goals, they can stop doing what is not working. If you can get definable benchmark measures, that's a better way of determining whether you are succeeding.

## LOOKING AHEAD

**ROWLAND:** With so many centers of influence and power in health care, how do we implement some of the ideas laid out here today?

**OWCHARENKO:** There has to be buy-in from stakeholders. One interest I have with respect to moving forward — especially relative to reforming Medicaid with a large piece of legislation that will revolutionize the system — is allowing states to test things and then to look at how to redirect monetary incentives toward getting good outcomes. Having stakeholders buy into this new approach may be easier than shaking your finger and telling them they have to do it this way.

**WILSON:** We need more trust between the states and the federal government; without that, we cannot move forward. We are always looking over our shoulders at each other now, and you can't really proceed with that kind of relationship. Part of that is a fiscal shell game, where we're moving too little money around. Somehow we have to get beyond that, to sit down in a position of trust, and have a conversation about what we can do — whether it's incremental or revolutionary.

**ROWLAND:** But some of that goes, I assume, to your point of also having a division of who does what, governor.

**ENGLER:** Yes, I think states would be more effective than Washington. Here's a lit-

tle advice from a former governor: Legislative organizations and governors' organizations should determine if they can sit at the same table and come up with the same proposal. They have hurt themselves in the past by having different or slightly different proposals. If you give a little bit of daylight to Congress — to say you don't know what you want because you have different proposals — you're dead. States have to unify around a concept and try to sell it. That's Washington.

At the state level, it's a different story, and what has been said here is quite on target, but I do think I would examine who is going to win in the budget. The obvious candidate for getting behind this, for doing something a bit differently, is the educational community. The K-12 schools and the universities ought to be willing to come to a meeting and say, "Let's work together to do something a little different." They have their own health care costs, so they are not detached from that perspective. Certainly, though, with respect to budgetary needs, they don't have this under control — and they are the ones getting squeezed out.

**WEIL:** Again, I will object to the question, because the premise is faulty. Medicare and Medicaid were created when the traditional model of health insurance was the Blue Cross claims-payer model. Medicare still is overwhelmingly a fee-for-service system; only in 2006 will we start seeing prescription drug coverage. It does nothing for long-term and chronic care. The practice of medicine and the organization of medicine have changed little over time, whereas Medicaid has developed systems to meet chronic needs of populations, stepped in to address the HIV/AIDS epidemic, and worked with systems to respond to people with traumatic brain injuries that would have been fatal at the time the program began. There's certainly more good to be done with Medicaid, but it is highly responsive to changes in the health care system — certainly relative to other big payers.

The harder question is how to get the broader health care system to engage in these discussions, as opposed to thinking that these are just Medicaid issues. Because again, imperfect as it is, and with all the ideas for improvement we've discussed today — and many more that we haven't had time to get into — state governments, governors, and legislators are less likely to fight over things at an etiological level and are more inclined to try to figure out how to solve problems to the extent that they can. This is a program that has evolved, and it will continue to do so. We shouldn't let today's problems, as real as they are, make us think that the program can't respond to challenges.

**ROWLAND:** Going back to Gov. Engler's opening comment, that Medicaid is too big to fail, the challenge then is how to provide all those services. An exercise we've been engaging in at the Kaiser Commission on Medicaid and the Uninsured is envisioning a world without Medicaid, asking how all those responsibilities would be handled and how all those holes would be filled.

While we may differ on strategies for putting the program out into the future, we're here today because we know this nation requires something that is like Medicaid, even if we rename it. The future of Medicaid is the future of how we care for ills that fall through the cracks in our society.

